Docket No.: 50-325 License No.: DPR-62

EA 92-208

FILE COPY

Carolina Power and Light Company ATTN: Mr. R. A. Watson Senior Vice President Nuclear Generation Post Office Box 1551 Raleigh, North Carolina 27602

Gentlemen:

SUBJECT: NOTICE OF VIOLATION

(NRC INSPECTION REPORT NOS. 50-325/92-35 AND 50-324/92-35)

This refers to the Nuclear Regulatory Commission (NRC) inspection conducted by Mr. D. Nelson on October 2 - 30, 1992, at the Brunswick Steam Electric Plant. The inspection included a review of the facts and circumstances related to the inadequately controlled Unit 1 reactor water level draining evolution which resulted in the inadvertent low level isolation of shutdown cooling on October 2, 1992. The report documenting this inspection was sent to you by letter dared November 9, 1992. As a result of this inspection, violations of NRC requirements were identified. An enforcement conference was held on November 2. 1992, in the NRC Region II office, Atlanta, Georgia, to discuss the violations, their cause, and your corrective actions to preclude recurrence. A list of attendees at the enforcement conference and a copy of your handout are enclosed.

The violations in the enclosed Notice of Violation (Notice) resulted from the October 2, 1992 event. At the time of the event, Unit 1 was in operational condition 4 (cold shutdown) as a result of a forced outage which began on April 21, 1992. The event involved an inadvertent decrease of reactor vessel water level to the Reactor Protection System (RPS) actuation level setpoint of 165 inches which caused automatic RPS trip and Primary Containment Isolation System (PCIS) group isolations that secured the level decrease, but resulted in a loss of shutdown cooling. Although the event was a direct result of operator inattentiveness due to distractions during critical plant operations, there were other significant contributing factors that preceded the final personnel error which caused the actual event. Even though these contributing factors developed sequentially, a collective evaluation of those :actors strongly indicates that the root cause of the event was inadequate management control of facility licensed activities. The inspection report provides the specific details associated with these contributing factors such as the loss of a level alarm due to a plant modification installation; excessive control room distractions; insufficient command, control and communication; and inadequate outage planning and scheduling.

Violation A in the Notice involved failure to follow a procedure wherein the inattentiveness of the reactor operator (i.e., he was reviewing a docum nt unrelated to plant operations) resulted in the reduction of reactor vessil water level to the point of RPS and PCIS actuation on Low Level 1. Contributing to the reactor operator's actions was the indirect inattentiveness of the senior reactor operator due to excessive administrative duties and the continuing tolerance by Operations management to allow long standing control room distractions. Additionally, the inadequate scheduling and planning of outage activities put the operators in a challenging situation that could have been avoided.

Violation B in the enclosed Notice involved the failure to effectively communicate to the operators that equipment and instrumentation had been disabled as a result of clearances associated with a plant modification. Specifically, an on going modification to the Feedwater Control System disabled the only audible high/low reactor vessel water level alarm in the control room. In addition, there had been no positive communication to control room operators that the modification installation caused the audible alarm not to function. This was a significant oversight because reactor vessel level control was being maintained manually by the operators and the low level alarm would have lessened the potential for inadvertent draining of the reactor vessel. The operator who was involved in the event of October 2, 1992, was not aware that the low level alarm had been disabled.

The staff acknowledges the comments received during the enforcement conference with regard to the broader underlying cause of Violation B and considers those comments indicative of your thorough analysis of this event. However, the staff considers that in this event the clearance process should have provided the communication mechanism and therefore, the characterization of the violation has not changed. The staff recognizes that other process procedures may exist to address this issue and your response to this violation should not be limited to the clearance process.

After careful consideration of this matter, the NRC staff has concluded that the safety significance of this event was mitigated by the fact that automatic Emergency Core Cooling System injection was available had the reactor vessel water level continued to decrease, and because of the low initial temperature and low decay heat rate due to the plant being in cold shutdown conditions. Therefore, the violations are categorized at Severity Level IV. However, the distraction of control room personnel with non-operational duties is of significant concern. Excessive senior reactor operator administrative duties was also identified as a contributing cause to previous operating events. Additionally, the act of manipulating critical reactor parameters warrants undivided attention and failure to do so represents an error in fundamental watchstanding operating practices. This requires prompt management attention.

The staff recognizes that immediate corrective action was taken when the event occurred and that a Site Incident Investigation Team was established to review the event and develop a Root Cause Analysis. Also viewed as significant was the fact that independent outside participation was requested and provided by the Institute of Nuclear Power Operations.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Should you have any questions concerning this letter, please contact us.

Sincerely,

Original signed by: Jon R. Johnson/for

Ellis W. Merschoff, Director Division of Reactor Projects

Enclosures:

1. Notice of Violation

2. Enforcement Conference Attendees

3. Licensee Handout

cc w/encls: R. E. Morgan Interim Manager Brunswick Nuclear Project P. O. Box 10429 Southport, NC 28461

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(cc w/encls cont'd - See page 4)

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RII:ORB RCarroll:tj 11/25/92 RII:DRP W HChristensen 11/1/92

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